Youth-Friendly Sexual and Reproductive Health Services: An Assessment of Facilities

Photo by Richard Lord

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African Youth Alliance

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ACRONYMS AND ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
ASRH	-	Adolescent Sexual and Reproductive Health
AYA	-	African Youth Alliance
BCC	-	Behaviour Change Communication
FGD	-	Focus Group Discussion
FP	-	Family Planning
HIV	-	Human Immunodeficiency Virus
IEC	-	Information, Education and Communication
MoH	-	Ministry of Health
NACP	-	National AIDS Control Programme
NGO	-	Non-Government Organization
PAC	-	Post Abortion Care
PE	-	Peer Educator
PI	-	Pathfinder International
RH	-	Reproductive Health
SDP	-	Service Delivery Point
SP	-	Service Provider
SRH	-	Sexual and Reproductive Health
STIs	-	Sexually Transmitted Infections
TDHS	-	Tanzania Demographic Health Survey
TRCHS	-	Tanzania Reproductive and Child Health Survey
WHO	-	World Health Organization
YFS	-	Youth Friendly Services

ACKNOWLEDGEMENTS

The Africa Youth Alliance (Tanzania) and Pathfinder International (Tanzania) offices coordinated the task of carrying out facility needs assessments for youth friendly services in eleven facilities in Tanzania between July and October 2002. The exercise was undertaken as a follow-up to another one conducted partly as a pre-project assessment for youth friendly services. The first task looked into broader issues for YFS, including policy, programming and service delivery. The facility needs assessments were confined to the proposed facilities and looked into issues such as the location, the hours of operation, the infrastructure, staffing and provider preparedness, range and quality of services, youth involvement, and supportive policies and administrative procedures.

The assessment covered 11 facilities as follows; (i) Ngarenaro health centre, (ii) Tarime district hospital, (iii) Kaloleni health centre, (iv) Levolosi health centre, (v) Mbagala dispensary, (vi) Infectious Disease Centre (IDC), (vii) University of Dar es Salaam RH clinic, Marie Stopes clinics in (viii) Ilala, (ix) Zanzibar, (x) Arusha and (xi) Mwenge.

A combination of Pathfinder staff, AYA staff and personnel from some of the implementing partner organizations were involved in conducting the assignment. AYA Tanzania and Pathfinder International (T) are indeed very grateful to the following for undertaking the task successfully: Naomy Achimpota, Gwyn Hainsworth, John Bosco Basso, Nsiima Mushumba, Paul Luchemba, Joan Mngodo, Lilian Mnzava, Dick Manongi, Joan James, Kania Msuri, Rose Baruti and Joyce Ferizi. They are especially thanked for their endless efforts to make sure that the exercise went smoothly.

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AYA Tanzania and Pathfinder International (T) would like to put on record that, all parties involved showed great interest and commitment during the field visits, as well as during informal and formal discussions.

Specific thanks also to Dr. Gottlieb S. Mpangile for reading the various assessment reports and drafting this document.

AYA Tanzania and Pathfinder International (T) consider this overview to be a sound basis for future plans to develop and implement effective Youth Sexual and Reproductive Health (YSRH) programmes and services in Tanzania.

EXECUTIVE SUMMARY

Young people in Tanzania are at risk from a broad range of health problems. Sexual and reproductive health behaviors are among the main causes of death, disability and disease among young people. They are at particular risk for unwanted pregnancy and related complications, STIs and HIV/AIDS. The need for sexual and reproductive health services for young people has, over the past years, become particularly critical for a number of reasons. Societal change caused by modernization and urbanization has led to the loosening of family ties, leaving many young people unable to rely on intergenerational relationships for information and guidance about responsible sexual behavior. As the gap between the generations is reinforced by cultural globalization, young people are increasingly left to learn about sexual issues from their peers or from the mass media.

One out of every three Tanzanians is a youth between the ages of 10-24. This implies that the sexual and reproductive health needs of youth cannot be ignored, given their numerical strength and, indeed, on the understanding that they are the future of the nation.

Young people face a number of SRH problems in Tanzania, including early sexual debut, unplanned teenage pregnancy, STIs and HIV/AIDS, unsafe abortion, female genital cutting (FGC), and sexual abuse/violence. The reproductive health needs of young people have been largely ignored by existing reproductive health services. Health care facilities can play an important role in promoting the sexual and reproductive health of young people. This can be achieved by improving the quality and range of services provided to youth and, in particular, by health care providers maintaining a friendly and open attitude as they impart accurate information and impartial advice.

The African Youth Alliance (AYA), a project implemented by UNFPA, PATH, and Pathfinder, has identified some of the critical issues affecting the sexual and reproductive health status of young men and women in the country. One of the strategic approaches of AYA is to make reproductive health care services more accessible and acceptable to youth. This implies making the services *youth-friendly.* Prior to starting programme activities, AYA conducted a needs assessment to determine the programming needs related to implementing youth-friendly SRH services within the Tanzanian context. The assessment looked into broader issues, including the policy environment, programme planning and implementation, and service delivery strategies.

As one of the first program activities, facility assessments were conducted in all the sites that AYA had selected to provide youth-friendly SRH services. This second round of assessments examined the extent to which facilities are youth friendly by assessing infrastructure, operational hours, location, service provision, staffing and provider preparedness, youth involvement, and policy and administrative issues related to service delivery. The two assessments found a number of gaps within the current service delivery framework, including:

- The services are designed for the adult client and service providers are not trained in adolescent sexuality and youth-friendly SRH concepts;

- Many of the facilities' working environments are not youth friendly, and services for adolescents are poorly publicized;
- Service provider attitudes and biases are a great barrier to adolescent services;
- Service providers do not have access to any policies, protocols or standards/guidelines related to providing quality youth-friendly SRH services;
- There are no peer programmes to link clinic services, and all services are designed, implemented, and evaluated without the involvement of youth;
- RH services provided are not comprehensive, and appropriate IEC materials were almost universally absent;
- Privacy and confidentiality were generally lacking;
- Condoms were not distributed at various vantage points, and condom shortages were very common.

A number of recommendations are made that include:

1. Service Delivery Points (SDPs) should use resources within their reach to make their facilities more youth friendly by allocating specific times and/or space to serve youth;

2. Although AYA is building the capacity of service providers among their implementing partners, there is a need for MOH and other partners to institutionalize such training programmes for national level reach and impact;

3. All SDPs should offer a range of services to youth, so that young people are able to address multiple SRH needs in one place. Counseling on sexuality and safer sex are needed to empower youth to make healthy decisions, including protecting themselves from unwanted pregnancy and STI/HIV;

4. IEC materials on adolescent SRH issues should be available at the SDPs to complement SRH services;

5. Privacy and confidentiality should be increased by minor renovations of facilities (e.g. partitioning of rooms or adding doors) and changes in the practice of providers (e.g. minimizing interruptions during client visits);

6. Availability of peer education through trained peer educators (PEs) is an added advantage in offering youth-friendly services. Therefore programme managers should be encouraged to include peer education services in their programmes.

7. The logistics of commodity and drug supplies should be strengthened to ensure that condoms and STI drugs are available to young people when they need them;

8. In line with decentralization, Council and Municipal Health Management Teams should consider inclusion of youth-friendly SRH care in their plans of operations for sustainability. Monitoring system and supportive supervision of youth-friendly SRH service delivery should be strengthened at district level;

9. AYA has introduced some data collection forms and formats and trained staff in MIS. Efforts are still needed to further institutionalize this if possible at the national level. It is recommended that the capacity of SDPs be strengthened with regard to proper record keeping and reporting systems (MIS). Service statistics should be compiled in a manner that captures sex and the 10 – 14, 15 – 19 and 20 – 24 age group categories;

10. SDPs and other interested parties should effectively involve youth in planning, implementation, and evaluation of their youth-friendly SRH programs;

11. Efforts by the MOH should be made to standardize the implementation of youth-friendly service delivery. Building on Pathfinder's characteristics and criteria of YFS, youth-friendly standards, guidelines, and protocols should be finalized, disseminated, and used in supervision;

12. AYA should continue its efforts in advocacy so as to improve the policy and service environment at all levels for youth- friendly SRH services. This is an essential intervention, and its importance cannot be overemphasized.

CONCLUSION

Existing initiatives to provide services to the youth need to be commended. However, there is an urgent need to build on their strengths and address their shortcomings. Plans to implement the set of recommendations listed above should be put in place and be part and parcel of the entire initiative. Given the findings and recommendations, AYA will strengthen the upgrading of selected model sites that could be used for replication in future scaling-up plans. The mandate of AYA is to contribute to the overall improvement of adolescent sexual and reproductive health in the country. Therefore, new ASRH initiatives should build on the best practices and lessons learned from AYA and develop activities that complement the work that has occurred thus far.

BACKGROUND

Introduction

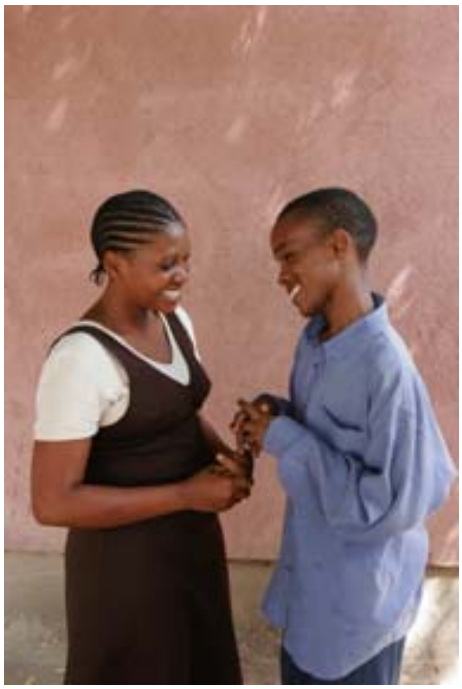

Photo by Richard Lord

Young people in Tanzania are at risk from a broad range of health problems. Sexual and reproductive health behaviors are among the main causes of death, disability and disease among young people. They are at particular risk for unwanted pregnancy and pregnancy related complications, STIs and HIV/AIDS. Other significant problems include: physical and psychological trauma resulting from sexual abuse, gender-based violence and other forms of physical violence and accidents. The youth are vulnerable to these problems because they often venture into sex unprepared; have sex with multiple partners; engage in alcohol and drug abuse that impairs judgment; have limited awareness of STI prevention; lack skills to negotiate safer sex; and have poor health-seeking behavior. Furthermore, Tanzanian youth find it difficult to access RH and HIV/AIDS services because the few services available are not friendly to them and are basically designed for adults. In addition, they commonly have no money, are without transportation, lack awareness of services available, are restricted from seeking SRH information and services and fear the stigma associated with seeking sexual and reproductive health care.

These problems gain urgency when actual numbers are considered. Indeed, the world is experiencing an unprecedented increase in the number of young people. It is estimated that, worldwide, one in every five persons today is a young person. According to the 2002 National Census, the estimated population in Tanzania is now about 34 million, of which, 31% are aged between 10-24 years. In other words, one out of every three Tanzanians is a youth according to the World Health Organization (WHO) definition. This implies that the sexual and reproductive health needs of the youth cannot be ignored given their numerical strength and recognizing that they are the future of the nation.

Teenage pregnancy

The median age at first intercourse for Tanzanian youth is quite low. Accurate statistics are difficult to come by, but a few studies done in the country indicate that this is true. A recent illustrative study conducted by GTZ in Lindi showed the median age of first sex for girls and boys as 11 and 14 years respectively. At the age of 19, more than half of the boys and girls have had sexual experiences. However, some study reports indicate that some girls begin having (coercive) sex as early as eight years of age. According to UNICEF, UNAIDS and WHO (*Young People and HIV/AIDS: Opportunity in Crisis*, 2002), 17% of young women and 14% of young men, ages 20-24, were sexually active by age 15. The Tanzania Demographic and

Health Survey (TDHS) of 1999 shows that by the time they reach 17 years of age, one woman in four has already begun childbearing. That proportion goes up to 46% by the time a woman turns 18. The pregnancy rate among teenagers age-wise, increases from 3% at 15 years to 54% by age 19. Adolescents between ages 15 and 19 account for 12% of the total fertility rate and youth in the age group 20-24 account for 24%. This implies that about 25% of female teenagers in Tanzania have already started bearing children.

Hospital-based data shows that teenage pregnancies contribute significantly to the high maternal mortality and morbidity rates in the country. It is estimated that nearly 20% of maternal deaths occur to young women below the age of 20 years, while the group aged 15 – 24 years accounts for up to 40% of all maternal deaths in the country.

> Nearly 40% of maternal mortality occurs among young women aged 15 – 24 years.

Early parenthood is likely to affect educational achievement with significant employment and socio-economic ramifications, while health complications for both the teen mother and unborn child are high. A considerable percentage of girls drop out of school every year due to unplanned pregnancy. In 1997 alone, 3,000 girls were reported to have dropped out of school because of pregnancy (Ministry of Education). This seems to be an underreported figure because the reasons for dropping out are not always known.

HIV/AIDS and STIs

Youth are at the center of the HIV/AIDS crisis in Tanzania. Although the majority have heard about AIDS, many still do not know how HIV is spread and do not believe they themselves are at risk. Even those who do possess information about HIV often do not protect themselves, because they lack adequate decision-making skills, social support, or the ability to adopt safer sexual behaviors. According to epidemiological report No. 16 of the National AIDS Control Programme (NACP), for the period January – December 2001, the number of new AIDS cases between 1983—when the disease was first discovered in the country—and December 2001, has increased from 3 to 71,000 per annum respectively. During the same reporting period, the cumulative number of people living with the HIV virus was estimated at 2,229,770. Youth aged 15-24 accounted for about 15.2% of the total. Other documented reports show that half of all HIV infections are acquired under the age of 25 and that females become infected at an earlier age than males. Data obtained from blood donors suggest that 12% and 8% of young females and males (15 – 24 years) respectively were HIV infected in 2001 (MOH/NACP 2001).

According to available data, the rate of sexually transmitted infections among youth is very high. Records at the infectious disease clinic in Dar es Salaam show that 55% of all STI clients seen between 2000/2001 were below 25 years of age (*ref. IDC/STD clinic data).* The HIV/AIDS/STI Surveillance report for 2001 documents a total of 211,291 episodes of STIs with the most affected age group between 20 – 29 years.

Condom use among youth in Tanzania is low, with the percentage of those who used a condom at last high-risk sex (defined as sex with a non-regular partner) in the past 12 months being 21% for females and 31% for males (ages 15-24) (UNICEF/UNAIDS/WHO, 2002). Less than 37% of young men ages 15-19 know the three primary ways of avoiding infection (i.e., abstinence, be faithful and consistent condom use), and 68% of girls ages 15-19 have at least one major misconception about HIV/AIDS or have never heard of AIDS (UNICEF, Multiple Indicator Cluster Surveys, Measure DHS, 1999-2001).

Unsafe abortions

An unplanned pregnancy can be a frightening, if not devastating experience for teenagers. This often leads them to seek unsafe clandestine abortions. A study conducted in four public hospitals in Dar es Salaam in 1992 on "Factors Associated With Induced Abortion" showed that, among 455 women who had induced abortion and developed complications necessitating hospital admissions; about one third (32.9%) were teenagers aged 19 years and below. Ninety-one respondents (about 20%) admitted to be students at either primary or secondary school level (*Mpangile, G. S. et al)*.

Furthermore various studies conducted at the then Muhimbili Medical Centre indicate that 50% of admissions due to abortion-related complications are youth aged between 15-24 and as many as 24% die from abortion-related causes (*Urassa et al*).

Fifty per cent or more of gynaecological admissions are due to abortion related complications - especially among the youth.

Other youth SRH issues

In addition to early sexual debut for boys and girls, a number of other risk factors are prevalent among Tanzanian youth. These include early and widespread alcohol and drug abuse, high prevalence of STIs other than HIV, pronounced gender power imbalances, female genital cutting and high rates of sexual coercion and abuse, especially for girls. Many adolescents also are exposed to sexual harassment and rape. In a study in Mwanza, 47% and 37% of sexually experienced girls in primary and secondary schools, respectively, reported having been forced into sex by either their fellow students or teachers.

The Quest to Address Youth SRH issues

The need to provide services that are specific and youth-focused has been recognized by a number of agencies. The Programme of Action adopted by the International Conference on Population and Development (ICPD) in Cairo in 1994 highlights and endorses the right of young people to information and services to meet their sexual and reproductive health care needs. Chapter 17 of the Programme of Action calls for the protection and promotion of the rights of young people to reproductive health education and care, and urges countries to remove all legal and societal barriers to such services.

The Government of Tanzania, in collaboration with non-governmental organizations and the private sector, has developed and implemented a number of small-scale programmes to address sexual and reproductive health needs of young people in the country. Most of these programmes have not been properly evaluated to assess their impact on the ground. It is therefore of critical importance that programmes are properly designed and implemented on an expanded scale to meet the many unmet needs of the youth. The youths themselves must be fully involved in the planning, implementation, and evaluation of such information and services.

The Africa Youth Alliance (AYA) Tanzania is one program that is developing and implementing such strategies. AYA is a partnership of UNFPA, PATH, and Pathfinder. AYA has identified many critical issues affecting the sexual and reproductive health status of young men and women in the country. Listed by priority, they include the following:

- Addressing the high STI/HIV/AIDS prevalence;
- Responding to the increased number of unwanted/unplanned teenage pregnancies;
- Addressing the increased incidences and prevalence of unsafe abortion.

AYA Youth Friendly SRH Initiative

Needs assessments conducted by AYA Tanzania confirmed earlier-known facts that most available sexual and reproductive health service outlets are specifically designed to serve adults, and youth feel intimidated to use such facilities. In addition, assessments found that the low rate of service utilization among youth - including their low contraceptive use - is attributable to a number of factors, including:

- Lack of access to youth-friendly services;
- Lack of information on availability of services;
- Poor skills among service providers on how to deal with youth;
- Stigma associated with seeking sexual and reproductive health services by youth;
- Limited understanding on the need for youth-friendly SRH services by parents, teachers, policy makers and faith leaders.

AYA sought to address the factors that hinder young people from seeking services by: 1) advocating with policy makers and other influential leaders on the need to support SRH services for young people; 2) promoting health-seeking behaviour and advertising youth-friendly services through BCC campaigns; and 3) offering youth-friendly SRH services at private and public-sector clinics. Pathfinder International (PI) is responsible for the youth-friendly service component, while UNFPA and PATH are responsible for advocacy and BCC respectively.

AYA's minimum package of youth-friendly SRH services include:

- Information and counseling on sexuality, safe sex and reproductive health;
- Contraception and protective method provision (with an emphasis on dual protection);
- STI diagnosis and management;
- HIV counseling (and referral for testing and care);
- Pregnancy testing and antenatal and postnatal care;
- Counseling on sexual violence and abuse (and referral for needed services);
- Post-abortion care (PAC) counseling and contraception (with referral when necessary).

AYA proposes to provide youth-friendly SRH services by:

- Building on what already exists using available facilities and service providers;
- Reaching young people through a variety of channels such as: static clinics, outreach (including peer education), and the private and commercial sectors;
- Promoting the use of condoms for dual protection;
- Establishing linkages with effective referral sites;
- Creating partnerships with other institutions for future scaling-up.

The AYA/PI strategy for institutionalizing youth-friendly SRH services includes the following:

1. Facility needs assessments, using the Clinic Assessment of Youth-Friendly Services tool to establish benchmarks for future evaluations and to identify areas for quality improvements. The assessments are done by a combination of AYA staff and personnel from the implementing partner organizations, using a variety of methods, such as interviews with management, service providers and clients, observations of the physical infrastructure and client-provider interaction, and a review of clinic statistics, policies and procedures;
2. Development and implementation of action plans for quality improvements based on the results of the facility assessments;
3. Training of service providers using Pathfinder's Reproductive Health Services for Adolescents curriculum. Among other things, the training includes: the vulnerabilities and needs of adolescents, communicating with the young client, counseling on safer sex and other SRH issues, and how to tailor SRH services to meet the needs of young clients;
4. Training of supervisors in supportive supervision of youth-friendly SRH services;
5. Provision of essential technical assistance and monitoring to the institutions', management and clinics as per identified needs.

YOUTH-FRIENDLY SERVICES

The concept and guiding principles

Pathfinder International has considerable international experience in adolescent SRH services and has developed a variety of tools for assessing, designing and implementing SRH services for young people. A principle strategic approach of AYA/PI is to make health care services more accessible and acceptable to youth. This implies making the services *youth-friendly.* Pathfinder International describes youth friendly SRH services as services that:

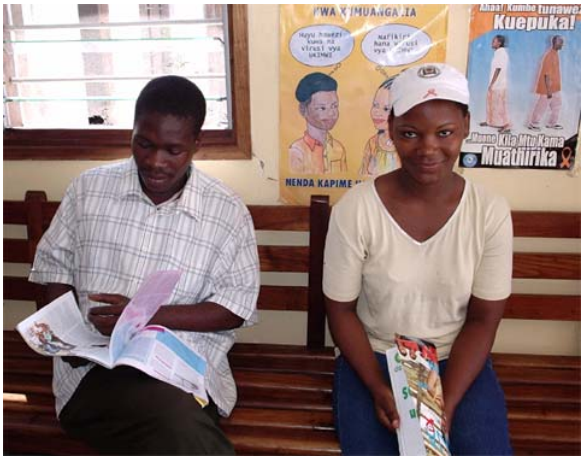

Photo by Gwyn Hainsworth

- Effectively attract young people;
- Meet the varying needs of young people comfortably and responsively;
- Succeed in retaining these young clients for continuing care.

Identifying and meeting the needs and expectations of the youth and the communities in which they live is an important feature of any successful youth-friendly initiative. Youth involvement and participation (YIP) is considered crucial to the success of the initiative. Services must be designed and implemented to meet the needs and aspirations of the intended youth clients as the beneficiaries. To achieve this, clinic staff must understand the needs of the youth being served and must empathize with them. Surveying youth to determine their needs is one of the first criteria that should be met.

Programme managers and service providers for youth-friendly SRH programmes should consider the following fundamental principles when designing and implementing youth friendly SRH services:

- Every young person is unique, and has different needs for health information and services based on a range of factors that include their age, race, gender, culture, life experiences, social situation, and physical or mental disability;
- The youth have inherent sexual and reproductive rights, including the right to a full range of reproductive health services;
- Gender inequities and differences that characterize the social, cultural and economic lives of the youth influence their health and development;
- The health needs of the youth are best addressed by a holistic approach that takes cognizance of their physical, mental and social wellbeing;
- The management of youth SRH needs includes the promotion of healthy development, the prevention of SRH problems, as well as the response to specific SRH needs;
- Community support is critical to sustainable youth health services and programmes;

- Youth participation in the planning, development and evaluation of services and programmes ensures that their needs are addressed in an appropriate manner.

Based on research and assessments, Pathfinder International has identified a set of key characteristics associated with youth-friendly SRH services. These elements differ in importance to effective service delivery and vary according to geographical area, culture, and various characteristics of the primary target audience (age, sex, sexual experience, residence, school status). For example, separate space and hours appear to be important to young adolescents and to those who are sexually inexperienced, while not nearly so important to older and more sexually experienced teens. Some characteristics, however, appear to be universally critical to young clients, including several provider characteristics: (specially trained, respectful, concern for privacy and confidentiality), convenient hours, and affordable fees (Senderowitz, J. 1999. *Making Reproductive Health Services Youth-Friendly.* Washington DC: Pathfinder/Focus on Young Adults Project).

Provider Characteristics

Staff trained in youth-friendly SRH: Providers who are trained to work competently and sensitively with young people are often considered the single most important condition for establishing youth-friendly services. Acquired skills must include familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity. At least as important are interpersonal skills so that young people can be at ease and can comfortably communicate their needs and concerns. In addition, all non-medical staff (e.g. receptionist, guard, etc.) should be oriented to the needs of young people.

All staff demonstrate respect and concern for young people: Young people often report that they are afraid to come for SRH services because a provider had previously shouted at them or criticized them for being sexually active. Although training can help some providers develop positive attitudes in their interactions with youth, occasionally there are providers who have personal biases or values that interfere with the provision of SRH services to youth. Therefore, providers should be carefully selected for YFS, based on their interest and willingness to work with young people.

Privacy and confidentiality are honored: Young people report that privacy and confidentiality are extremely important to them when making decisions about whether or not to seek SRH services. Many young people are afraid that a provider will share with a relative the reason for their visit or some other private information. Not only should records be kept in a confidential manner, but providers should be careful not to share personal information about a client with other people.

Adequate time is allocated for client and provider interaction: Adolescents are often shy about discussing issues related to SRH and often need to be encouraged to speak freely. Providers should assume that it will take more time for an adolescent to disclose their problems than it would for an adult and therefore allocate time appropriately. Providers should be able to respond to questions about body image and development, sex, relationships, and condom negotiation, as well as to clearly explain contraceptive method options and their possible side effects and

management. This discussion is crucial to the compliance and retention of the adolescent client.

Peer counselors are available: Many young people report that they feel more comfortable talking to people their own age about sensitive issues. Although for more technical issues, they tend to prefer adult providers. It is productive, therefore, to have peer counselors available as supplements for some aspects of counseling.

Health Facility Characteristics

Separate space or special times set aside for young clients: Creating separate space, special times, or both for adolescent clients appears more important for certain clients, such as younger adolescents, first-time clinic users, non-sexually active clients, and marginalized young people, who are especially suspicious of mainstream health care. Separate times can also allow providers to capitalize on non-peak hours so that they can allocate more time for young people and help increase privacy.

Convenient hours for young people: To increase access to SRH services, clinics must be open at times that are convenient for young people to attend. Such times include late afternoons (after school or work), evenings, and weekends. While young people who need urgent care may be willing to leave school or work for such services, those who need preventive services, but who may be unaware of their importance, are often reluctant to take time off.

Convenient location: Although some young people prefer to go outside their immediate community for care to avoid being seen, most young people cannot afford to travel long distances to access services. Therefore clinics should be easily accessible by foot or public transportation.

Adequate space and sufficient privacy: Both examination rooms and counseling rooms should offer both auditory and visual privacy. Interruptions during the client visit should also be kept at a minimum. Adequate space is also necessary for privacy and to assure that counseling and examinations can take place out of sight and sound of other people.

Comfortable surroundings: Young people often prefer environments that are clean, have adequate seating, and are decorated with cheerful colors and IEC materials. Young people are often not comfortable in overly sanitized environments.

Program Design Characteristics

Youth involvement in design and continuing feedback: To adequately address young clients' needs, youth should be involved in the design, implementation, and evaluation of services. There are many mechanisms that can be used to involve youth, such as surveying their needs prior to developing youth-friendly SRH services, using them as peer educators, soliciting their feedback through exit interviews, or mystery client assessments.

Drop-in clients welcomed and appointments arranged rapidly: Young people often do not plan ahead and therefore they are more likely to access services if they are able to be seen by a provider without an appointment. If an adolescent

is turned away and told to return at another time, or if the adolescent must wait several weeks to be seen after making an appointment, there is a significant likelihood that the potential client will not show up. With young people, it helps to "seize the opportunity" when they show an interest in getting RH care.

No overcrowding and short waiting times: Having to wait a long time to be served in a clinic is often cited as a barrier by young people. Young people often are not willing to wait for services; and if the facility is crowded, they are particularly worried that someone they know will see them while they are waiting.

Affordable fees: Cost can be a significant barrier to young clients. A fee schedule must be designed so that services are free or affordable. They can be established on a sliding scale, possibly including credit and flexible payment options. Often adolescents want to pay *something* for services or else they will not value what is provided.

Publicity and recruitment that inform and reassure youth: Adolescent clients must know that youth-friendly SRH services exist, the facility location, and its hours. It is important that any publicity on services also stresses that young people are welcome and that they will be served respectfully and confidentially.
Communicating this information can often be done as part of community mobilization efforts. Outreach in the community is particularly important in reaching out-of-school youth. Recruitment is often best handled by young people themselves, both formally (such as distributing printed information or making presentations) and informally (by word of mouth).

Boys and young men welcomed and served: Welcoming male partners can prove beneficial where feasible. For a young woman, the accompaniment of her boyfriend to the clinic can be an important element in the decision to seek services. Opportunities exist to foster shared responsibility for decision-making and contraception when young men are present, as well as to serve the needs of males for RH information, counseling, and service. It may be necessary to develop clinic programs designed especially for young males that are sensitive to male values, motivations, feelings, and cultural influences while encouraging equitable male and female relationships. Other outreach programs, especially involving condom distribution and STD/HIV prevention have proven successful in targeting or reaching males.

Wide range of services and contraceptive methods available: The more health needs of young people that can be met within the facility or program, the greater the assurance that they will receive the care they need. Whenever it is necessary to send young people to another location for another service, there is an increased risk that they will not actually show up. While it is not always possible, attempts should be made to identify and provide the most needed RH services as "one-stop shopping." These services should include sexual and RH counseling, contraceptive counseling and provision, STD and HIV prevention, STD diagnosis and treatment, nutritional services, sexual abuse counseling, prenatal and postpartum care, and prevention and management of abortion and its complications.

Necessary referrals available: It is desirable, but almost never possible, to provide services that meet all the needs of adolescents, including some types of specialized health care and related social services. Thus, it becomes very important in addressing the adolescent's overall needs to be able to refer to responsible agencies. Effective working arrangements should be established to ensure that youth receive referral services and that referral sites provide appropriate, youth-friendly treatment.

Other Characteristics

Educational material available on site and to take: Some young people prefer to learn about sensitive issues on their own, using written or audiovisual materials, because their discomfort level can be too great to retain information during a face-to-face session. Such material can be used while clients are waiting to be seen. Some materials should be available to take home for later review, particularly if the topics are complicated (such as symptoms of STDs).

Group discussions available: While not all young people are comfortable in a discussion setting with their peers, this type of information exchange can be very productive. It helps adolescents to realize that they are not unique in their fears and can provide peer support to obtain needed care or seek solutions to problems.

Delay of pelvic examination and blood tests possible: A policy that has been pioneered in some youth-friendly clinics is the possibility of delaying procedures feared by young people, especially the pelvic exam and blood tests. This fear can deter young women from going to clinics and obtaining contraception when they first need it. When it is deemed safe that such procedures can safely wait until a subsequent visit, this approach might encourage early clinic visits and earlier adoption of a contraceptive method.

Alternative ways to access information, counseling, and services: Given the challenge of attracting young people to fixed clinic sites, clinics can increase their reach by other means of contact with clients. Telephone hot lines, for example, can be operated by trained counselors from the clinic site, so that clients need not come to the clinic for information or counseling. Peer or adult counselors and outreach workers (including community-based distribution agents) can go into the community to deliver services. For some young clients, one of these models will serve as an intermediate approach to on-site clinic use, until they become more comfortable or their situation becomes more urgent. Clinics can also set up smaller branches or satellite clinics closer to where young people congregate or that are linked to schools. (Pathfinder: Clinic Assessment of Youth-Friendly Services: A Tool for Assessing and Improving Reproductive Health Services for Youth, and Senderowitz: Making Services Youth Friendly).

THE NEEDS ASSESSMENTS FOR YOUTH-FRIENDLY SERVICES IN TANZANIA

Prior to starting programme activities, a pre-project needs assessment was undertaken in 2001 in the three districts of Dar es Salaam, the Arusha municipal council and Zanzibar and Pemba. The exercise addressed issues such as the SRH needs of young people, the policy environment, programme planning, and implementation. During the pre-project needs assessment, the assessment team visited 23 public and private (NGO) facilities in order to understand what type of SRH services are currently available to Tanzanian youth and to identify gaps in service provision.

After the facilities that would offer youth-friendly SRH services under AYA had been selected, 11 facility assessments were conducted between July and October 2002 to ascertain the level of youth friendliness in the selected project sites, as well as to make recommendations for improvement. Publicly-owned facilities and those managed by NGOs in Dar es Salaam, Tarime, Arusha and Zanzibar included (i) Ngarenaro Health Centre, (ii) Tarime District Hospital, (iii) Kaloleni Health Centre, (iv) Levolosi Health Centre, (v) Mbagala Dispensary, (vi) Infectious Disease Centre (IDC), (vii) University of Dar es Salaam RH Clinic, Marie Stopes clinics in (viii) Ilala, (ix) Zanzibar, (x) Arusha and (xi) Mwenge.

The main purpose and objectives for the facility needs assessment were as follows:

- To establish benchmarks of existing levels of youth friendliness in the selected facilities;
- To identify training needs of the service providers in terms of current knowledge, skills and attitudes that impact on SRH services for youth;
- To identify opportunities and areas for improvement in the provision of youth-friendly SRH services in the selected facilities.

Methodology

Pathfinder's Clinic Assessment Youth-Friendly Services tool was used by teams of AYA staff and personnel from the implementing partner organizations. Each facility was assessed by 2-4 assessors mentioned in the acknowledgement section of this report. The teams looked into the following issues:

i. Facility location;
ii. Facility operating hours;
iii. Facility environment and layout;
iv. Staff competency, knowledge, skills and training;
v. Client volume and range of services provided;
vi. Components of ASRH services and family planning methods offered;
vii. Peer education services;
viii. Youth involvement;
ix. Educational materials and activities;

x. Policies and administrative procedures that influence youth's access to services;

xi. Publicity and client recruitment procedures

xii. Services fees

The teams used the tool to guide interviews with facility managers, service providers, and young clients on site. The teams also used observation methods to examine facility environment, IEC materials, and client/provider interactions. Furthermore, the assessors reviewed policies, procedures, and clinic service statistics.

Assessment Process

The assessment teams initially briefed facility managers and supervisors to get their support in the exercise through short introductions to the AYA initiative in general and youth-friendly SRH services in particular. The Clinic Assessment Tool for Youth-Friendly Services was also explained and assurances given about the outcomes of the assessments in terms of improving quality provision. Invariably the facility managers and supervisors promised complete support and made the exercise easy and smooth.

The assessment was carried out during working hours so that clients could be interviewed and service provision to the youth could be observed. Team members were assigned different tasks including data collection, observation of client-provider interaction, interviewing clients, and interviewing service providers and management. After the assessments were conducted, the team met with the clinic manager and key staff to debrief them on the preliminary assessment findings and solicit their feedback and recommendations for improvement. A written report was then submitted to the clinic, and action plans were developed by the facility based on the assessment results and recommendations. In order to assist clinics in the implementation of their action plans for quality improvements, AYA is providing technical assistance as needed.

Findings

The following are some of the main findings of the facility assessment. It is important to note that many of the findings were also in line with the results of the pre-project needs assessment.

- Facility location: All facilities were urban-based and therefore geographically accessible to the communities. All of them were near some school facilities and other locations patronized by young people in the catchment areas. However, except for a few of them, the majority did not have any signs directing potential clients or indicating the type of available services. Some of the facilities decided to consult with the youth clients on what messages if any should be put on the signboards.

- Facility working hours: None of the facilities had arrangements for allocating specific times to provide services to young people. RH services were invariably only offered between 7.30–15.30. Indeed, this arrangement was seen as a barrier to services for most of the youth, given that it coincided with

school hours and work times. Young clients that were interviewed reported that afternoon and evening hours are convenient to them. Most managers agreed to explore the possibility of initiating youth-friendly services during those times.

- Facility environment: During the first needs assessment, 62.7% of the 51 young people interviewed at exit from SDPs said they prefer not to mix with adults receiving SRH services, and they would feel more comfortable if they were attended to in a separate room. However, none of the facilities assessed dedicated separate waiting or consultation space to youth. In addition, many of the facilities labeled their rooms so that clients could quickly identify where to go for certain services. For many young people this was viewed as a barrier, since they did not want to enter a room that was labeled "family planning" or "STI clinic" in case someone from their community saw them. Furthermore, reproductive health services are traditionally offered in maternal and child health (MCH) clinics, and young men reported that they would rather self-treat a STI than be seen at a MCH clinic seeking treatment.

  In nearly all the public facilities, the environment was assessed as being non-friendly to the youth. The buildings were in need of various types of repairs and needed painting and some partitioning. In all instances, relevant IEC materials were conspicuously absent. Most of the time, the places were crowded with clients of all ages, thus rendering the facilities rather intimidating for the youth.

- Privacy: Young people also were concerned with privacy and confidentiality. There was a fear that the provider would share their personal business with adult community members. Lack of privacy was a major issue in nearly all the public facilities visited. Some of this was due to the physical setup (e.g. lack of doors or lack of space), and some was due to practices (e.g. multiple interruptions, leaving doors open during client visits). In a couple facilities, two or more clients were served at the same time in the same room. This made it very difficult for young people to express themselves, especially when they had problems like STIs. Most assessed facilities could make simple changes that would improve confidentiality and privacy, such as erecting doors to examination rooms, not leaving doors open, minimizing interruptions when a client is being served, and ensuring that records are stored in a confidential manner. However, one needs to note that the situation was considerably different (for the better) in the NGO facilities and the IDC clinic in Dar es Salaam.

- Staff: All facilities were reported to have almost the required numbers of staff for basic RH services. Although the pre-project needs assessment found that service providers had received formal training in different areas of RH (specifically FP), the facility assessments found that many providers in the actual project sites had not received basic RH training. In addition, service providers had not received any training in providing effective youth-friendly SRH services, nor were there any job aids on adolescent reproductive health. Most staff relied on past "experiences" in performing their duties. Many of the

providers interviewed seemed interested in serving young people and wanted to be involved in YFS training.

- Provider attitude: Provider attitude was often cited by youth as a barrier to accessing SRH services. Providers reported that they were often uncomfortable addressing the problems of adolescents because they had not been trained in youth-friendly services. In addition, some providers had their own personal bias against providing adolescents with contraception or felt that young people should not be sexually active, thus hindering services to the youth.

- Supervision: There was evidence of routine on-site supervision, but generally, supervision from higher levels was ad hoc and not facilitative in nature. During the pre-project assessment, only about 28% of facility managers appeared to approve of the provision of SRH services to the youth. One in five (20%) were completely against such a practice, while the remainder was undecided. However, during the facility assessments, it was found that there was an increased support for the provision of youth-friendly SRH services. This was due in part to having been signed on as partners under AYA . Many managers had been sensitized to the need for SRH services. However, there still remains a need for managers to be trained in supervision related to youth friendly SRH services. Good supervision is needed for the implementation of a new initiative such as youth-friendly SRH services. Otherwise providers will forget what they learned during training and resort to their usual practices and biases.

- Client volume and range of services: Basic RH services were available in most of SDPs, although services were not geared specifically to youth. As was found in the pre-project needs assessment, most facilities provided family planning, ante- and post-natal care, and management of STIs. However, no facility was reported as providing a comprehensive set of RH services as stated in the minimum package. Only Marie Stopes clinics offered a wide range of services. Post-abortion care, counseling on sexual abuse, and substance abuse services were available in only about a quarter of the facilities. VCT services were available in nearly half of the facilities. Counseling on youth sexuality issues was virtually non-existent in nearly all public-sector facilities, with the exception of IDC. Condom promotion and distribution was low and only within the framework of family planning services.

- Quality of services: During the pre-project assessment, the majority of the youth generally expressed dissatisfaction with the quality of services received. Nearly 80% said they did not spend adequate time with the providers, about 90% felt that the providers did not listen to them and did not allow them to ask questions, while another 80% were not happy with services at the reception. During the facility assessments, youth also reported these issues. In addition, most young clients reported that procedures were often not explained to them and that providers did not routinely discuss prevention of pregnancy and STI/HIV. However, it is important to note that young people were generally happy with the quality of services received at Marie Stopes Clinics and IDC. In this regard, IDC can serve as a model for other public sector facilities.

- Equipment and supplies: Both during the pre-project needs assessment and the facility assessments, the basic equipment in clinics and laboratories were in working condition. However, facilities were in need of small sized specula to provide SRH services to youth. The only serious shortcoming was that the supply of drugs and expendables was irregular, as reported in 80% of the facilities. Condom shortages have significant implications for AYA, given that increasing condom use is one of its key goals to help young people prevent unwanted pregnancy and STI/HIV.

- Data collection and reporting: Nearly all the public sector SDPs visited had poor and outdated recording systems and did not have regular monthly/quarterly reports. Service statistics were not routinely aggregated by age or sex. There were serious gaps in record keeping, and there was no attempt anywhere to gather and analyze data on youth SRH needs.

- Peer programmes: The pre-project needs assessment found that in-school youths realized the existence of ASRH problems like STI/HIV, drug/substance abuse and pregnancies but were not comfortable seeking care in existing health facilities; some just kept quiet, hoping the problem would resolve on its own, while others sought help from friends (*from FGDs*). Peer education programmes and outreach activities were perceived by the youth as being effective and useful. However, none of the facilities assessed had a functional peer outreach programme within the catchment area.

- Youth involvement: The team established that in nearly all instances, there was minimum (if any) involvement of the youth in the design, implementation and evaluation of the SRH services. In addition youth were not involved in any on-going or planned activities in the sites. Only the IDC in Dar es Salaam had specific programs designed and implemented by youth on Saturdays.

- Policies/protocols: The National Family Planning Policy and Service Guidelines were generally understood in most facilities. However, the written policy documents were not available in any of the facilities visited. There were no adolescent-specific service policy guidelines and standards to direct the delivery of appropriate youth-friendly services. In Zanzibar, providers complained that a policy that unmarried young people under the age of 18 who fall pregnant are jailed is detrimental to youth-friendly SRH services. In terms of quality assurance, some protocols that enhance quality service delivery were available in many of the facilities visited. For example nearly all places did have some infection prevention protocols in place.

- Administrative procedures: In general, clients are seen on a 'first-come first-served basis". However, a few clinics in Arusha municipality had a policy of serving boys and girls in school uniforms on a priority basis. Generally clients spent between half and hour to two hours waiting to receive services, Issues of client confidentiality were poorly addressed - especially with regards to records keeping. Client records were often kept in the open and anyone could have access to them.

- Fees: The majority of young clients (61.3%) interviewed during the pre-project needs assessment said that the fees charged for various RH services were

not affordable. The facility assessments also showed that services offered by NGOs were often unaffordable to youth, although many considered the public sector services affordable. Public sector facilities reported free provision of consultations, STI drugs, and condoms. However, there are some costs now under the cost-recovery scheme (e.g. urinalysis, registration, and injections) that are not always affordable to youth.

- Promotion of YFS: In order to attract young people to clinics, the location and services of the clinic must be well publicized. The facility assessments revealed the need to strengthen the promotion of services. Most young clients reported first learning about clinic services by word of mouth. NGO clinics face an additional challenge in publicizing their youth-friendly programs, because a law restricts private clinics from advertising their services through mass media. However, even simple measures such as signboards in the community listing the hours, location, and services of the clinic would increase awareness of youth-friendly services. Outreach by peer educators or other community health workers has also proven to be an effective means of promoting services. During the first needs assessment, the team noted that there was a minimum of advocacy-related activities to promote youth-friendly SRH services.

ANALYSIS AND IMPLICATIONS OF FACILITY NEEDS ASSESSMENT RESULTS

The findings of the facility needs assessment further confirm earlier conclusions that the concept and practice of youth-friendly services is still new in Tanzania and not yet institutionalized. The principles that guide the provision of youth -friendly services find their base in recognition and incorporation of all elements of **quality of care.** The assessment concludes that there is still a great need to improve the quality of services to young people.

The infrastructure setup provides challenges that may call for increased investments and commitment to provide high quality youth-friendly SRH services. Given that young people aged 10-24 make up 33% of the population and they are the future of the nation, commitment to providing them with SRH services that will protect them from unwanted pregnancy and STI/HIV is imperative. To ensure more resources, additional advocacy may have to be applied to enhance government commitment to both better quality of care and to make services more youth-friendly.

In the near term, critical changes must include:

- rearranging client flow so that adolescents are better served (e.g. offering YFS during non-peak hours such as afternoons);
- minor rehabilitation of facilities (e.g. adding doors, partitioning of rooms);
- changes in procedures (e.g. reducing the number of interruptions when a client is being served or closing doors to counseling rooms) to increase privacy;
- building the capacity of providers to effectively address adolescents' SRH problems through training and supportive supervision;
- procuring job aids and relevant IEC materials on ASRH.

The IDC facility in Dar es Salaam is a good example. The facility has recently gone through a number of infrastructural changes, including those undertaken through AYA to improve quality of care and make the facility youth-friendly. In addition, staff have been trained by AYA in youth-friendly services, as well as in STD/HIV/AIDS prevention and care under other programs. Since improving the quality of services to young people, IDC has seen a significant rise in the number of youth clients. IDC proves that it is possible for public-sector facilities to improve their services so that they become youth-friendly.

RECOMMENDATIONS AND CONCLUSIONS

A number of recommendations are made on the basis of the findings of the two needs assessment exercises conducted by AYA Tanzania. However, it is not possible to overemphasize the need for total commitment by decision makers and programme managers at all levels to maintain high quality and youth friendliness as top priorities. This commitment should invariably be translated with a ready willingness to allocate additional resources to address identified gaps in quality of care and youth-friendly services.

1. Service Delivery Points (SDPs) should use resources within their reach to make their facilities more youth friendly. Where feasible, separate times should be allocated for servicing the youth within existing facilities. The selected times should be the most convenient for the youth and consideration can be given for afternoons and weekends to enhance privacy. Where possible, the provision of separate space for young people could reduce the stigma of coming for ASRH services to clinics that are crowded with clients of all ages and descriptions.

2. Although AYA is building the capacity of service providers within their implementing partners, there is a need for MOH and other partners to institutionalize such training programmes for national level reach and impact. In addition, MOH should ensure that trained personnel are deployed in the facilities offering youth-friendly SRH. Health management teams should receive intensive and purposeful orientation to get them to effectively support the provision of YFS.

3. All SDPs should offer a range of services to youth, so that young people are able to address multiple SRH needs in one place. Counseling on sexuality and safer sex are needed to empower youth to make healthy decisions, including protecting themselves from unwanted pregnancy and STI/HIV.

4. BCC materials on adolescent SRH issues should be available at the SDPs to complement SRH services. Materials that can be taken away are also needed, so that young people can learn on their own. In addition, job aids that will assist providers in rendering services to the youth are also needed.

5. Privacy and confidentiality should be increased through small rehabilitation of facilities, such as the partitioning of rooms or adding doors or screens. In addition, changes in provider practices, such as minimizing interruptions during client visits or shutting doors or windows when clients are being served, will also increase privacy. Records should be stored in a confidential manner so that others do not have access to client information.

6. Trained peer educators (PEs) are an added advantage in offering youth-friendly services. Therefore programme managers should be encouraged to include peer education services in their programmes. Their selection should be done with the involvement of youth in collaboration with local communities. Given the proximity of schools to all identified health care facilities, both in- and out-of- school programs should be established.

7. The logistics of commodity and drug supplies should be strengthened to ensure that condoms and STI drugs are available to young people when they need them.

8. In line with decentralization, Council and Municipal Health Management Teams should consider inclusion of youth-friendly SRH care in their plans of operations for sustainability. Monitoring systems and supportive supervision of youth-friendly SRH service delivery should be strengthened at the district level.

9. Fortunately in Tanzania, RH services are still offered free of charge in the public sector. However, efforts should be made to start sensitizing communities on the importance of cost-sharing for service provision and quality improvement. Determination of fees for services offered should involve youth themselves. Some services provided by the peer educators, e.g. condom distribution, could be offered at a price with the youth making some contribution. Some of the funds obtained could subsequently be used to motivate and sustain the peer educators.

10. AYA has introduced some data collection forms and formats and trained staff in MIS. While this is an important first step, this process should be institutionalized at the national level. The capacity of SDPs be should strengthened in proper record keeping and reporting systems (MIS). Service statistics should be compiled in a manner that captures sex and the 10 – 14, 15 – 19 and 20 – 24 age group categories.

11. SDPs and other interested parties should effectively involve youth in planning, implementation and evaluation of their youth-friendly SRH programs. A variety of strategies can be used to enhance youth involvement, e.g. soliciting regular feedback from young clients and networking with existing youth groups.

12. The MOH should standardize the implementation of youth-friendly service delivery. Building on Pathfinder's characteristics and criteria of YFS, youth-friendly standards, guidelines, and protocols should be finalized, disseminated, and used in supervision.

13. AYA should continue its advocacy efforts to improve the policy and service environment at all levels for youth- friendly SRH services. This is an essential intervention, and its importance cannot be overemphasized.

Conclusion

Existing initiatives to provide services to the youth should be commended, but there is a strong need to build on their strengths and address their shortcomings urgently. Plans to implement the recommendations listed above should be put in place and be part and parcel of the entire initiative. Given the findings and recommendations, AYA will strengthen the upgrading of selected model sites that could be used for replication in future scaling-up plans. The mandate of AYA is to contribute to the

overall improvement of adolescent sexual and reproductive health in the country. Therefore, new ASRH initiatives should build on the best practices and lessons learned from AYA and develop activities that complement the work that has occurred thus far.

REFERENCES

1. Scaling Up Youth-Friendly Services. Concept Paper. 2002. AYA.
2. African Youth Alliance (AYA) – Tanzania Annual Report. 2002. AYA.
3. AYA Rapid Needs Assessment for Kigoma, Arusha, Tarime, Zanzibar and Pemba. 2001. AYA.
4. Needs Assessment Report for Youth Friendly Services in Tanzania. 2002. AYA.
5. HIV/AIDS/STI Surveillance Report, January – December 2001, Report No. 16 of the National AIDS Control Program (NACP).
6. Draft Report National Census 2002.
7. Tanzania Reproductive and Child Health Survey (TRCHS), Key Findings 1999.
8. *Induced Abortion in Dar es Salaam, Tanzania: The Plight of Adolescents*. Abortion in the Developing World. 1999. World Health Organization. Article by Mpangile, G.S et al. Geneva: WHO.
9. Standards for Youth Care, A Guide to the Youth-Friendly Services Initiative. Dickson, K., W. Moleko and G. Mpangile. RHRU/IPPFAR.
10. Clinic Assessment of Youth Friendly Services: A Tool for Assessing and Improving Reproductive Health Services for Youth. 2002. Senderowitz, J., C. Solter, and G. Hainsworth. Watertown: Pathfinder International.
11. Senderowitz, J., G, Hainsworth, and C. Solter. 2003. A Rapid Assessment of Youth Friendly Reproductive Health Services. Technical Guidance Series. Watertown: Pathfinder International.
12. Reports of the Clinical Assessment of Youth Friendly Services (i) Ngarenaro health centre, (ii) Tarime district hospital, (iii) Kaloleni health centre, (iv) Levolosi health centre, (v) Mbagala dispensary, (vi) Infectious Disease Centre (IDC), (vii) University of Dar es Salaam RH clinic, Marie Stopes clinics in (viii) Ilala, (ix) Zanzibar, (x) Arusha and (xi) Mwenge.